Access to Mental Health Services 2018 Interim Study
WICHE Follow-up Items from Third Meeting: Sep. 11, 2018

- Mandatory suicide prevention training: how long have the states had the training, what kind of funding supports it, and is there a correlation in terms of increases or decreases in suicide rates?
    - It is important to note that as there are a number of other factors that could account for why a state's suicide rates could change over time, changes may not be indicative of the effectiveness of mandatory training.
    - States with mandatory training for health care professionals:

State	When Adopted*	Funding*	Changes in suicide rates^
California	Adopted 9/1/17. Effective 1/1/20.	Qualifying graduate degree program, as part of applied experience, or by taking a continuing education course.	N/A
Indiana	4/28/17	Division of Mental Health and Addiction developed and provides a SAMHSA-approved training. Providers must complete a SAMHSA-approved training course as part of continuing education requirements	N/A
Kentucky	3/19/13	Part of continuing education requirements (i.e., health care professional pays).	2012: 16.2 2013: 15.5 2014: 15.9 2015: 17.1 2016: 16.8
Nevada	6/8/15	Part of continuing education requirements (i.e., health care professional pays).	2014: 19.6 2015: 18.4 2016: 21.4
New Hampshire	5/7/15	Part of continuing education requirements (i.e., health care professional pays).	2014: 17.8 2015: 16.6 2016: 17.3
Pennsylvania	7/8/16	Part of continuing education requirements (i.e., health care professional pays).	N/A
Tennessee	5/19/17	Part of continuing education requirements (i.e., health care professional pays).	N/A
Utah	3/23/15	Part of continuing education requirements (i.e., health care professional pays).	2014: 20.5 2015: 22.5 2016: 21.8
Washington	Adopted 3/29/12. Amended in 2013, 2014, 2015, 2016, & in 2017	Part of continuing education requirements (i.e., health care professional pays).	2011: 14.2 2012: 14.5 2013: 14.0 2014: 15.2 2015: 15.4 2016: 14.8

* State Laws: Training for Health Professionals in Suicide Assessment, Treatment, and Management, American Foundation for Suicide Prevention (AFSP), http://afsp.org/wp-content/uploads/2018/02/AFSP_Health-Professional-Issue-Brief-2-5-18.pdf.

^ Center for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS), Fatal Injury Data, https://www.cdc.gov/injury/wisqars/fatal.html. Most recent data available is 2016.

- States with mandatory annual training for school personnel

State	When Adopted	Funding Source*	Changes in suicide rates*
Alaska	2012	State Dept. of Education	2011: 19.4 2012: 23.0 2013: 23.0 2014: 22.0 2015: 26.9 2016: 25.4
Delaware	2015	State Dept. of Education	2014: 13.2 2015: 12.5 2016: 11.5
Georgia	2015	State Dept. of Education	2014: 12.6 2015: 12.7 2016: 13.3
Kansas	2016	State Dept. of Education	N/A
Kentucky	2010	State Dept. of Education	2009: 13.5 2010: 14.2 2011: 15.1 2012: 16.2 2013: 15.5 2014: 15.9 2015: 17.1 2016: 16.8
Louisiana	2008	State Dept. of Education	2007: 11.9 2008: 12.0 2009: 10.8 2010: 12.3 2011: 12.5 2012: 12.4 2013: 12.3 2014: 14.3 2015: 15.3 2016: 14.1
Maryland	2018	State Dept. of Education	N/A
Nebraska	2014	State Dept. of Education	2013: 11.7 2014: 13.4 2015: 11.6 2016: 13.0
Tennessee	2016	State Dept. of Education	N/A
Texas	2015	State Dept. of Education	2014: 12.2 2015: 12.5 2016: 12.6

* State Laws: Suicide Prevention in Schools (K-12), American Foundation for Suicide Prevention (AFSP), http://afspq.org/wp-content/uploads/sites/4/2018/04/AFSP_K-12-Schools-Issue-Brief-2-5-18.pdf.
^ Center for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS), Fatal Injury Data, https://www.cdc.gov/injury/wisqars/fatal.html. Most recent data available is 2016.

- Clarification on Mental Health Professional Shortage Area (HPSA) designations
    - HPSA designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. There are three categories of HPSA designation based on the health discipline that is experiencing a shortage: 1) primary medical; 2) dental; and 3) mental health. For more information on shortage areas see: https://bhw.hrsa.gov/shortage-designation.
    - Seven components are used in Mental Health HPSA scoring. For more information on the scoring process see: https://bhw.hrsa.gov/shortage-designation/hpsa-process.
    - Practitioners needed to remove the Mental Health HPSA designation is the number of additional psychiatrists needed to achieve a population-to-psychiatrist ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated) in all designated mental health HPSAs, resulting in their removal from designation. While mental health HPSA designations can include core mental health providers in addition to psychiatrists, most mental health HPSA designations are currently based on the psychiatrists only to population ratio. HPSA designations based on psychiatrists only do not take into account the availability of additional mental health services provided by other mental health providers in the area, such as clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists. (Source: https://www.kff.org/state-category/providers-service-use/health-professional-shortage-areas/).
    - All eligible Psychiatrists are included in Geographic HPSAs. Only Psychiatrists who accept Medicaid and/or Sliding Fee Scale are eligible to be counted for Low Income and Medicaid Eligible Population HPSAs. Psychiatrists that serve at VA or Military facilities are not included as they serve at facilities that are not open to the general public. (Source: email communication from HRSA).
- Clarification on state psychiatric hospital inpatient rates.
    - The number of state hospitals was based on 2015 State Mental Health Profiles
        - All states had at least 1 state hospital in 2015.
    - The number of state hospital residents that was used to calculate the rate was based on data states reported to SAMHSA as part of the 2016 Uniform Reporting System (URS). Thus, the data is likely reflective of what ever populations states serve in their state hospitals (e.g., adult, adolescent, geriatric, forensic, etc.). Data would also likely reflect states that have eliminated.
    - DHS provided the following information about South Dakota's URS data:
        - The information does include the geriatric population. This is due to all patients admitting to the acute units and then transferring to the nursing home part of HSC if community services are not available. In most cases, the acute units will work to return the geriatric client to their referring nursing home or to a nursing home if they meet qualifications.
    - South Dakota's data for 2016 can be found at: https://www.samhsa.gov/data/sites/default/files/SouthDakota-2016.pdf

- For details on the data used for the state psychiatric hospital inpatient rates see pages 40 and 50 of Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014. Available at: http://nri-inc.org/our-work/nri-reports/trends-in-psychiatric-inpatient-capacity-united-states-and-each-state-1970-to-2014/

- Could changes from the Diagnostic and Statistical Manual of Mental Disorders version four to version five (DSM IV to DSM V) affect data presented?
  - Data shared that used the DSM was based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Thus, differences between the DSM-IV and DSM V would not affect the data presented.
- What is the sample size (number of participants) for South Dakota's National Survey on Drug Use and Health (NSDUH) data?
  - NSDUH is an annual survey of the U.S. civilian, noninstitutionalized population ages 12 years or older. NSDUH interviews approximately 70,000 people for this study annually.
  - State and regional level data reflects a combination of multiple survey years. State and regional level estimates are based on a small area estimation (SAE) methodology in which state-level NSDUH data are combined with county and sub-county level census data from the state. The number of individuals who completed a survey in a state are not reported, but rather the estimated number of people is generated through statistical methods.
  - For more information on State Reports see: https://www.samhsa.gov/data/nsduh/state-reports-NSDUH-2016.
  - For more information on Substate Reports see: https://www.samhsa.gov/data/nsduh/2014-2016-substate-reports.
  - For more information on Substate and SAE methodology see: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsubstateMethodology2016/NSDUHsubstateMethodology2016.pdf.